Volume 11, Issue 1

BUREAU TALK

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Annual Statistical Reports

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It is once again that time of year when the bureau reminds agencies about the upcoming annual statistical reports. The data collected for both home health and hospice has not changed; however, the format for both reports has been updated to better facilitate the agency in entering the data. The only other difference this year is that the data will be submitted to the bureau instead of to Missouri Alliance for Home Care (MAHC) or the Missouri Hospice and Palliative Care Association (MHPCA).

To assist agencies with the completion of the statistical reports, the provider associations once again agreed to provide an educational webinar or teleconference. MAHC has already provided a free webinar for home health agencies on Wednesday, December 15, 2010.

The MHPCA also plans an educational teleconference for hospice providers.

Date:	January 4, 2011
Time:	11:00 a.m.
Call In Number:	218-936-4700
Access code:	318300

The bureau reminds all provider types that submission of annual statistical reports is a requirement for licensure in the state of Missouri, based on Statutes of the Department of Health and Senior Services, Division 30 – Division of Health Standards and Licensure, Bureau of Home Care and Rehabilitative Standards. (RSMo 197.420 for home health and RSMo 197.256 for hospice) **These reports are due on or before January 31, 2011. If the reports are not submitted by this date, a deficiency will be cited.**

Agency Administrator Changes

Per federal and state regulations, any administrator change in a home health or hospice entity must be appointed and approved by the governing body of the agency. Before any administrator change will be approved, the agency must submit a resume for the appointee, as well as, the governing body minutes approving the appointment of the new administrator. For home health, because the requirements for administrator allow for a licensed physician or registered nurse, only a copy of their current license along with the governing body minutes is required. These requirements can be found at CFR 418.100(b) and 19 CSR 30-35.010 (1) for hospice and CFR 484.14(b) for home health.

Hot Line

In the July 2010 Bureau Talk, the bureau informed providers of the change in hours for the Department of Health and Senior Services Hotline effective May 1, 2010. The bureau has received several phone calls as to whether this hotline continues to be available 7 days a week. To clarify, the Senior Services Hotline number is available 24 hours a day, 7 days a week. The only change is that it is now being manned with a live person from 8:00 A.M. to 8:00 P.M. daily. Outside of these hours, the caller will get a message to call back during 8:00 A.M. to 8:00 P.M. The caller cannot leave a message. Agencies don't need to reprint their admission forms, but rather cross out old hours and add new ones.

Licensure by Accreditation

In the history of the bureau, licensure by accreditation has never been allowed. The Department of Health and Senior Services has recently changed its practice and Licensure for home health and hospice by an accrediting organization is now allowed. All agencies currently on our "Pending Agency" list have been notified of this change.

Face to Face Encounters

The Centers for Medicare & Medicaid Services (CMS) has issued the final rule related to the 2011 requirement for face-to-face encounters for hospice and home health patients. Because this regulation concerns payment issues, any questions regarding interpretation of this regulation should be addressed to the fiscal intermediary. The bureau has contacted the fiscal intermediary and it is recommended that providers access their website for reference tools addressing this new regulation. Their website is www.cahabagba.com and reference tools can be found at http://www.cahabagba.com/rhhi/education/materials/quick_homehealth_face.pdf and http://www.cahabagba.com/rhhi/education/materials/quick_hospice_face.pdf.
The final rule can be accessed electronically at http://www.cms.gov/HomeHealthPPS/HHPPSRN/list.asp#TopOfPage.

FCSR/EDL/Criminal Disclosure Statement/Criminal Background Check

Frequently, the bureau receives questions from providers addressing one of the following four issues. In the April 2006 Bureau Talk, the bureau published an explanation of each and how it relates to either home health or hospice. Since that was several years ago we have decided to republish the information.

EDL (Employee Disqualification List) ***(Applies to both Home Health and Hospice)***
Any entity that receives EDL information under Missouri Revised Statutes, Chapter 660, Department of Social Services, Section 660.315, which includes any entity licensed under Chapter 197 (Home Health and Hospice), must perform an EDL check on all employees **prior to hire.**

FAMILY CARE SAFETY REGISTRY (FCSR)**(*Applies to Home Health only)***
This applies to a home health agency (HHA) only; however, hospices may choose to use the FCSR to obtain information on EDL and Criminal Background Checks.
Prior to patient contact (Missouri Revised Statutes, Chapter 660, Department of Social Services, Section 660.317), the HHA must verify employee is **registered** with the FCSR. For survey purposes, a copy of the registration **and the results** must be in the employee file. This will also give you the EDL and the Criminal Background Check.

Any employee with a class A or B felony violation of chapter 565, 566 or 569, or any violation of subsection 3 of section 198.070, RSMo, or section 568.020, RSMo, cannot have **patient contact** unless a Good Cause Waiver has been **GRANTED** by the Department of Health and Senior Services.
Any employee with any other FCSR finding cannot have **patient contact** without a Good Cause Waiver application having been **SUBMITTED t**o the Department of Health and Senior Services. For survey purposes, if a Good Cause Waiver is required (either submitted or granted), there must be documentation in the employee file.
FCSR/Good Cause Waiver Access Line: 1-866-422-6872 (Mon-Fri, 7:00 A.M. – 5:00 P.M.) Internet Site http://www.dhss.mo.gov/FCSR/index.html.

CRIMINAL DISCLOSURE STATEMENT ***(Applies to both Home Health and Hospice)***
Per Missouri Revised Statutes, Chapter 660, Department of Social Services, Section 660.317(5)(2), "An applicant for a position **to have contact with patients or residents** of a provider shall: Disclose the applicant's criminal history. For the purposes of this subdivision "criminal history" includes any conviction or plea of guilty to a misdemeanor or felony charge and shall include any suspended imposition of sentence, any suspended execution of sentence or any period of probation or parole; and…"

CRIMINAL BACKGROUND CHECK *(Applies to both Home Health and Hospice)*
Per Missouri Revised Statutes, Chapter 660, Department of Social Services, Section 660.317(3) (1), "Prior to allowing any person who has been hired as a full-time, part-time, or temporary position to have contact with any patient or resident, the provider shall,….(1) Request a criminal background check…."

HOSPICE ISSUES

MO HealthNet Reminders

MO HealthNet would like to remind providers of the following regarding election statements:

- include all terminal diagnoses on the election form using valid diagnosis codes
- include the hospice provider NPI or MO HealthNet provider number
- include attending physician name and NPI or MO HealthNet provider number
- be sure the attending physician and medical director date and sign the certification form.

For questions regarding hospice election statements and certification dates contact *Clinical Services* at: 573-751-6963.

Please note: If you attended the Midwest Regional Conference on Palliative Care and End of Life Care, there was misinformation in Lisa's slides regarding this issue.

Drug Enforcement Administration (DEA) Policy Reversal

Effective October 6, 2010, the DEA has issued a statement of policy to provide guidance under existing law regarding the proper role of a duly authorized agent of a DEA-registered individual practitioner in connection with the communication of a controlled substance prescription to a pharmacy.

In summary, Congress has recognized the roles of "agents" as an authorized person who acts on behalf of or at the direction of a dispenser. Likewise, DEA regulations now permit a practitioner to use an authorized agent to perform certain ministerial acts in connection with communicating prescription information to pharmacies. These acts would include hand delivery, facsimile (after the prescriber's signature), telephone calls, or sending an electronic transmission after the prescriber has provided the signature. As explained in a more detailed chart (ATTACHMENT A) the proper role of an agency depends upon the schedule of the controlled substance prescribed, the circumstances of the ultimate user and the method of communication.

For more detail on this issue: http://www.deadiversion.usdoj.gov/fed_regs/rules/2010/fr1006.htm.

Revised Hospice State Operations Manual

On October 1, 2010, the State Operations Manual (SOM), Chapter 2 – Certification Process, Sections 2080 – 2089 for Hospice and Appendix M – Guidance to Surveyors, was updated to reflect the revised Hospice Conditions of Participation that were effective December 2, 2009.
Please see ATTACHMENT B.

Hospice Crossing State Lines

As per the Hospice State Operations Manual (SOM), October 1, 2010, "When a hospice provides services across State lines, it must be certified by the State in which its CMS certification number (CCN) is based, and its personnel must be qualified in all States in which they provide services….The involved States ***must*** have a written reciprocal agreement permitting the hospice to provide services in this manner…"
In the state of Missouri, there is no reciprocal agreement for hospice. Those agencies that are seeing hospice patients currently across the state lines were "grandfathered in" December 16, 2005. However, the revised SOM now states, "…States ***must"*** have a written reciprocal agreement; and, because Missouri does not have a reciprocal agreement with other states for hospice, these agencies will no longer be allowed to see patients across state lines. Those agencies involved with this change have been notified by Centers for Medicare and Medicaid Services (CMS).

HOME HEALTH ISSUES

Homebound Status

Effective for dates of service on and after October 1, 2010, the homebound requirement in the MO HealthNet Home Health Program is removed from policy and the Medicaid State Plan. All other requirements for the Home Health Program remain the same. The text of the provider bulletin and a link to the bulletin on the Department of Social Services/Division of MO HealthNet is:
http://dss.mo.gov/mhd/providers/pages/bulletins.htm.
A contact number for MO HealthNet is:

Provider Communications - 573-635-8908 or 573-751-2896 or through the Provider Communications Management link at www.emomed.com for questions regarding claims.

OASIS BY JOYCE RACKERS

Q&A's

The latest installment of the CMS' OASIS Q&As has been posted to the CMS and OCCB's website. These Q&As can be accessed by going to the OCCB website at www.oasiscertificate.org and click on the *Q&As and Core Docs* page under the *Resources* tab or go to www.qtso.com and click on OASIS. This CMS release covers 18 OASIS-C specific questions, including instruction related to:

- Payment regulation and instructions for Single Visit Episodes
- Use of M0100 "RFA 7 – Transferred to an inpatient facility – patient discharged from agency"
- New guidelines for Pneumococcal Polysaccharides Vaccine (PPV) administration, surgical wounds and patient medication teaching criteria
- Impact of outpatient therapy on reporting discharge disposition

Please note that in the July 2010 Bureau Talk we referred providers to the QIES website for the *OASIS Management for Single Visit at Start of Care (SOC) or Resumption of Care (ROC)* table. As noted in the October 2010 Quarterly Q&As, this document is now retired. **DO NOT USE THIS DOCUMENT.** At any time point where an OASIS assessment will impact the payment, even if that assessment visit is a single visit in a quality episode, completion and submission of OASIS data is mandated for payment. For agencies compliant with required data collection timeframes, the only time point where a single visit could impact payment is at the Start of Care (SOC). The discharge OASIS is never mandated in situations of single visits in a quality episode (SOC/ROC to TRF/DC).

PLEASE PRINT ALL OF October 2010 Q&As AND SHARE WITH YOUR CLINICAL STAFF!

OASIS-C Process Measure Reports

The OASIS C Process Measure Reports are now available in the CASPER Reporting System. The reports are located in the *OASIS C- Quality Improvement* report category.

Also, in the July 2010 Bureau Talk, the link to the new Process-Based Quality Improvement Manual was provided. The updated *Outcome-Based Quality Improvement (OBQI) Manual* and the *Outcome-Based Quality Monitoring (OBQM) Manual* are also now available! These can be accessed by going to the CMS website at http://www.cms.gov/HomeHealthQualityInits/.

PLEASE PRINT THESE MANUALS FOR THE PERSON IN YOUR AGENCY RESPONSIBLE FOR QUALITY/ PERFORMANCE IMPROVEMENT!

OASIS On-Line Training

The bureau recently contacted CMS inquiring about available on-line CMS OASIS training for providers. The following OASIS C training videos are now available on YouTube:

The Process Based Quality Improvement (PBQI) process.
http://www.youtube.com/watch?v=hNno1GIVAPA

Accurately Responding to Process Items: Intervention Synopsis (M2400)
http://www.youtube.com/watch?v=XrPJ85GQJVg

Accurately Responding to Process Items: Plan of Care Synopsis (M2250)
http://www.youtube.com/watch?v=H7mdobdIXr4

Accurately Responding to Process Items: Fall Risk Assessment (M1910)
http://www.youtube.com/watch?v=gUFeQZWQycY

CMS is also working with a contractor to develop modules (like talking Power Points) for posting in the future. They have almost finished the module on medications (all the medication items) and have plans for several others. The bureau will send out an email via list-serve when those are available.

Claim Denials for OASIS Data Submission Failures

One of the Missouri home health agencies recently shared with the bureau information they recently read in the October 19, 2010 NAHC Report (Issue #1574). Although the information is more a billing issue and not a clinical OASIS issue, the bureau decided to share it with other agencies. If you are a National Association for Home Care & Hospice (NAHC) member you may already be aware of the article.

It states, "The National Association for Home Care & Hospice (NAHC) recently learned that at least one contractor for the Centers for Medicare & Medicaid Services (CMS) has begun auditing home health claims for OASIS data submission during the conduct of medical review. In cases where OASIS start-of-care or recertification data for episodes under review were not submitted to the state, claims were denied in full. Up to this time, penalties for failure to submit OASIS data have been limited." CFR 484.20 Condition of Participation states, "HHA's must electronically report all OASIS data collected in accordance with 484.55.". The bureau has always monitored agencies to ensure OASIS data was being electronically submitted and have cited agencies that have not done submissions. This NAHC article is now informing agencies that, not only can the agency be cited for not following the CoPs regarding submission criteria, but the fiscal intermediaries are now becoming stricter and if OASIS is not submitted timely, they will be imposing penalties. Per the NAHC article, "Guidance on application of OASIS data submission as a requirement for payment was issued to CMS contractors in a June 2010 Change Request

Claim Denials for OASIS Data Submission Failures Cont.

(CR) update to the Medicare Program Integrity Manual, Chapter 3 Section 3.4.1.1. Also for further explanation please refer to the Federal Register, November 2009

(http://edocket.access.gpo.gov/2009/pdf/E9-26503.pdf).

The CMS Quarterly Q&As, Question #1, as noted above, also addresses this issue.)
In summary, NAHC urges home health agencies to carefully analyze their OASIS data collection and submission procedures, including attention to the processes and timeliness of their outside vendors. To ensure compliance with OASIS data submission as a **condition of payment**, agencies must submit OASIS start of care and recertification assessment data to the state prior to submitting final Medicare claims. Furthermore, agencies must ensure that the HIPPS code on the final claim matches that received on the OASIS validation report.
Because this is a billing issue, if you have any questions please notify your fiscal intermediary.

OASIS-C and Surveys

We are now in a new federal fiscal year. OASIS-C has now been in use for almost a year. Prior to now, if an agency was having difficulty answering the OASIS-C appropriately, the surveyor primarily educated the provider, rather than issuing a citation. Beginning with surveys for this new fiscal year, the surveyors will be looking more closely at the OASIS document and its accuracy. If a deficient practice is found, an agency is susceptible to a citation.

To assist both the surveyor and the agency, an OASIS Audit Tool was developed. Please see ATTACHMENT C. One area of deficient practice the surveyors have already found on survey concerns M2000 and the medication review. As you aware, M2000 is only answered for the Start of Care OASIS (SOC) and the Resumption of Care (ROC) OASIS. However, the Conditions of Participation at CFR 484.55(c) Tag G337 states, “The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and noncompliance with drug therapy.” Therefore, the medication review must be completed as part of each comprehensive assessment for the start of care, resumption of care, recertification, and discharge.

OASIS AUTOMATION BY DEBI SIEBERT

Single Registered Providers

A significant number of providers only have one registered user for the OASIS System.

If your only registered user resigns, then your agency is left without appropriate access to OASIS Submissions and CASPER Reports.

The bureau strongly urges each provider to have at least **two** registered users to avoid being without access to the OASIS System.

Remove User Account Request Form

This form must be completed by a agency in order to remove access of an existing individual user to an agency in situations such as termination or turn over. Please see ATTACHMENT D.

OASIS Corporate Access Request

This form must be completed in order to designate a corporate user to submit assessments on an agency's behalf, **remove access** of a current corporate user to an agency in situations such as termination or turnover. Please see ATTACHMENT E.